December 27, 2024

Dr. Meg Sullivan, Acting Assistant Secretary
Administration of Children and Families, Department of Health and Human Services
Mary E. Switzer Building,
330 C Street, SW
Washington, DC 20201

RE: Request for Information: Administration for Children and Families Development of Interoperability Standards for Human Services

Dear Acting Assistant Secretary Sullivan:

Civitas Networks for Health ("Civitas") appreciates the opportunity to respond to the recent Request for Information (RFI) on the development of interoperability standards for human services under the jurisdiction of the Administration for Children and Families (ACF), published in the *Federal Register* on October 28, 2024 (2024-24924, 89 FR 85540). Civitas is a national nonprofit collaborative comprised of more than 175 member organizations—health information exchanges (HIEs), regional health improvement collaboratives (RHICs), quality improvement organizations (QIOs), All-Payer Claims Databases (APCDs), and providers of services to meet their needs—working to use data frameworks, information infrastructure, and multi-stakeholder, cross-sector approaches to improve health for individuals and communities. We educate, promote, and guide the private sector and policymakers on matters of interoperability, quality, coordination, and cost-effectiveness within the health system.

Civitas members do not directly deliver the human services supported by ACF programs. Yet in an increasingly interconnected service ecosystem, our members' work with data is what enables the effective operation, development, and delivery of these services to the people who need them most, while achieving the greatest return on the public's investment. Civitas HIEs operate across statewide or regional geographies (in most cases, as entities officially designated by state statutes or agencies) and curate individual patient records using data that overlaps with eligibility factors for TANF, Head Start, LIHEAP, Title IV-E foster programs and others. Our RHIC members in turn act on this data by combining the capabilities of healthcare practitioners and paraprofessionals with public and private social service agencies and other local community-based organizations (CBOs) into value-based payment networks following the community care hub model. Civitas APCDs and QIOs incorporate program beneficiary data into analytics, which further drive continuous improvement in healthcare delivery and government benefits utilization for the most chronically underserved. And as the health information landscape continues to evolve with technology and adapt itself to changing federal and state policy, these roles and capabilities are reflected in the emergence of the Health Data Utility (HDU) model as a mechanism of multi-stakeholder oversight and public accountability—with Civitas members leading the way.

The common thread to these activities is a systematic approach that integrates both clinical and non-clinical information (health-related social needs data, or HRSN) required to provide whole-person coordinated care for patients and to develop effective stakeholder responses to community needs. At the most fundamental level, success depends on being able to make use

of data from a wide range of sources as quickly as possible, which only happens at scale if that data adheres to uniform standards. Standardization for payment, public health, and performance assessment continues to progress through well-established channels (CMS introduced 230 new CPT codes and 344 HCPCS codes this year alone, while CDC accepted 78 new ICD-10 codes) covering multiple co-occurring systems of electronic specification. However, the incorporation and utilization of relevant non-clinical data into these systems still lags behind clinical data, and the gap has become a distinct vulnerability as the digital and value-based care transitions accelerate. HIEs can, for example, collate individualized longitudinal data on ED admissions, chronic disease, and prescriptions from different inpatient and outpatient providers, Medicaid, and commercial claims (from the payers directly or via APCDs) in tandem with community-level population heath indicators from public health authorities (PHAs). Yet when providers refer a patient to the social services of a local organization (or the PHA attempts to track and evaluate these services in a given area) the data collection and processing often fragments for lack of common elements and sufficiently representative codes.

To address the problem, Civitas strongly supports federal efforts to establish forward-looking baselines that can assimilate new and regularly improved content and technical standards for HRSNs alongside medical needs, using the United States Core Data for Interoperability (USCDI/USCDI+) terminology with HL7 Fast Healthcare Interoperability Resources (FHIR) architecture and mediated through ASTP's Interoperability Standards Advisory (ISA) process. With CMS, CDC, HRSA, NIH, NCI, and FDA all adopting USCDI components since 2020, ACF would need an exceptionally good reason to *not* also participate—and given the significant practical overlap between ACF's human service programs and the HRSN elements already part of USCDI, ACF non-participation would be a serious blow to human service interoperability at large. ASTP is currently mandating the adoption of USCDI version 3 by January 1, 2026 (when version 1 will officially expire) as a requirement for federal HIT certification. CMS is doing the same for patient access APIs, while its provider access and payer-to-payer APIs have until January 1, 2027. As the RFI notes, USCDI v3 incorporates social determinants in four data element categories that are retained in version 4 (with a 2028 adoption date) and version 5.

Within the USCDI-FHIR framework, Civitas and several of our members have partnered with like-minded organizations to build and test prospective data elements that are responsive to the specific interoperability challenges we encounter on the front lines of data exchange. ACF is already familiar with the Gravity Project collaborative, which has produced some of the most impactful work in this area, and which counts Civitas as a participant alongside HHS agencies (ASTP, CMS), industry (Epic, BCBS, Humana, AMA) and other national stakeholders. The Gravity Project's focus on FHIR-aligned standards for social determinants is especially important for breaking down CBO interoperability barriers, designing data components so that they answer to the "social care voice," as ACF-funded Community Action Agencies and CBOs more broadly were described by a 2023 Civitas and Gravity working group. Gravity's insights are also uniquely informed by four ongoing pilots that it is sponsoring in Arizona, New York, Colorado, and Oklahoma to demonstrate real-world integration of new HRSN elements, all of which involve Civitas HIEs as the links between providers, CBOs, and PHAs on the state and local level.

The demonstrations, plus other test cases drawn from recent section 1115 HRSN waivers have highlighted the functional significance of developing the payment and "protective factor" data

element domains as priorities for Gravity stakeholders. As it seeks guidance on emerging areas of focus with a FHIR foundation, ACF should likewise prioritize these domains as part of its interoperability strategy. Payment data elements that Gravity is currently building for a future version of USCDI include Medicaid eligibility verification, Medicaid enrollment and commercial payer enrollment, as well as service documentation and claim submission. While many Civitas HIEs can already access this information to varying degrees and in different formats within their service areas (via SMA and APCD connections), uniform national content and technical standards across HHS divisions, state agencies, and human service providers without the need for further translation would be a major step forward for streamlining program administration through cross-agency verification.

Protective factors refer to those social determinants which help individuals mitigate health risks, build resiliency, and achieve better outcomes—essentially the "positive" inverses of the HRSNs that have been recorded to date through existing USCDI data classes. Gravity and its contributors are focusing on such protective factors as food access, neighborhood/community safety, financial security, and health literacy because of their value to critical specialties with extensive ACF alignment (pediatrics, nursing, social work) and because they are a necessary step to operationalizing more complex metrics like social network assessment. Incorporating these factors as USCDI-FHIR standards also strengthens and complements existing federal resources like the FEMA and HUD vulnerability indices.

On behalf of Civitas and our members, thank you again for the chance to comment on this RFI and for considering our recommendations. The Civitas community is deeply engaged in multiple corners of the health data policy and regulation space, and we stand ready to collaborate to achieve our shared goal of creating a higher-value health system.

Please do not hesitate to reach out if you have any questions or comments for us.

Sincerely,

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